



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

BRYAN RADIOLOGY ASSOCIATES

**Respondent Name**

FREESTONE INSURANCE CO

**MFDR Tracking Number**

M4-14-1278-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JANUARY 7, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We are writing in reference to [Claimant] and the denial of his claim for past the filing deadline. At the time of the patient's services we were unaware of this service being covered under Workers Compensation."

**Amount in Dispute:** \$332.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2013	CPT Code 72148-26-77 Lumbar MRI	\$332.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - 29-The time limit for filing has expired.
  - 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service.
  - OA-The amount adjusted is due to bundling or unbundling of services.
  - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

- 247-A payment or denial has already been recommended for this service.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 15, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### **Issues**

Did the requestor support that disputed bill was submitted timely?

### **Findings**

According to the explanation of benefits, the respondent denied reimbursement for the disputed lumbar MRI based upon reason code "29."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The respondent noted on the explanation of benefits that the disputed bill was received on October 16, 2013. The requestor did not submit any written communication outlined in 28 Texas Administrative Code §102.4(h) to support position that the disputed bill was sent timely to the respondent. The Division finds that the requestor has not supported position that bill was submitted in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

07/25/2014  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**